

§ 447.55

State payment for the service	Maximum copayment
\$10.01 to \$25	1.15
\$25.01 to \$50	2.30
\$50.01 or more	3.40

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(4) For Federal FY 2009, any copayment that the State imposes for services provided by a managed care organization (MCO) may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system. When there is no fee-for-service delivery system, the copayment may not exceed \$3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and § 431.57 of this chapter, for non-emergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of

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the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (c) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

[43 FR 45253, Sept. 29, 1978, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or co-payment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

§ 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to